CONSENT TO RELEASE INFORMATION

Utah Department of Health Division of Community and Family Health Services
Children with Special Health Care Needs Bureau
ABLE Program
44 North Medical Drive, P. O. Box 144660
Salt Lake City, UT 84114-4660

As Parent/Legal Guardian/Self (circle one), I request that records be released regarding the following child:

Name:_____ Date of Birth:_____

Current Address:_____ City:_____

State:_____ Zip:_____ Phone Number:_____

as indicated below:

☐ **I consent to the release** of information held by _____ to the Utah Department of Health, Children with Special Health Care Needs Bureau. Please send material to:

Children with Special Health Care Needs Bureau
44 North Medical Drive, P. O. Box 144610
Salt Lake City, UT 84114-4610

☐ **I consent to the release** of information held by the Utah Department of Health, Children with Special Health Care Needs Bureau to: Name:_____

Organization:_____

Address:_____

This release is for the following type of information as checked below:

☐ Achievement	☐ Dental	☐ Immunization	☐ School Testing
☐ Admit/Discharge Summary	☐ Developmental	☐ IQ/Psychological	☐ Social Services
☐ Attendance	☐ Feeding/Nutrition	☐ Lab/Medical Imaging	☐ Speech/Language
☐ Behavioral	☐ Growth	☐ Medical	☐ Surgical Reports
☐ Birth/Newborn Records	☐ Hearing	☐ Newborn Screening Tests	☐ Vision
☐ Community Staffing	☐ IEP/IFSP	☐ OT/PT	

☐ Other Explain:

I understand that I may withdraw this consent to disclose information at any time by notifying you in writing. This consent remains **effective for one year** from the date last signed.

Signature:_____ Relationship to child:_____ Date:_____

Signature:_____ Relationship to child:_____ Date:_____

Signature:_____ Relationship to child:_____ Date:_____

Signature:_____ Relationship to child:_____ Date:_____

Signature:_____ Relationship to child:_____ Date:_____

Signature:_____ Relationship to child:_____ Date:_____

For questions regarding this request, contact:

Program: _____

Name: _____

Phone: _____